Incidence of systemic lupus erythematosus among 255 patients with uveitis of unknown origin

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Ann Rheum Dis 2002;**61**:471

In reviewing the literature we have noticed a great difference in the prevalence of systemic lupus erythematosus (SLE) in patients with uveitis. Rosenbaum and Wernick found a prevalence of 0.1%,[1] according to the results from several wide American series published in the 1980s. In contrast, Rodríguez *et al* found a prevalence of 4.8% in a very heterogeneous population studied retrospectively, and analysed during the same period of time.[2]

We aimed at determining our experience on the incidence of SLE in patients with uveitis by a prospective study carried out during the past decade. Since 1989, the uveitis unit at our hospital has comprised an interdisciplinary team of internists and ophthalmologists carrying out an aetiological protocol study of patients with uveitis of unknown origin.[3–5] Up to 1999 we had prospectively studied 255 patients with uveitis; none of them had been previously diagnosed with systemic diseases which might have caused uveitis. Three patients met the 1982 revised classification criteria of the American College of Rheumatology for SLE,[6] representing 1.2% of our total uveitis cases. Table 1 shows the clinical features and associated pattern of uveitis; cutaneous involvement (malar rash and photosensitivity) was the most common clinical manifestation. Keratoconjunctivitis sicca, which is the most common SLE associated ocular manifestation of the anterior segment of the eye, was present in one patient. On the other hand, none of our patients had retinal vasculitis, and the ocular inflammation responded to topical treatment in all cases.

The prevalence of pathological processes associated with uveitis is variable, and depends on geographical factors, the specialty of the doctor, the hospital where the patients are studied, the retrospective or prospective nature of the study, diagnostic criteria, inclusion of subjects who use drugs by the parenteral route, or HIV infected patients, and inclusion or not of patients with diseases previously known and which cause uveitis. We believe that our results showed accurately the real incidence of SLE among patients with uveitis in our environment: firstly, because we excluded those patients with SLE diagnosed before the ocular inflammation appeared, which might have produced an overestimation of the final number of cases with SLE and, secondly, because of the prospective nature and long follow up of the study.

Thus patient 2 was diagnosed with SLE three years after the first visit because of uveitis. Rodríguez *et al* considered that SLE was becoming an important cause of anterior uveitis (3.3% of total anterior uveitis cases).[2] This is in accordance with our results because acute anterior uveitis was found to be the ocular pattern in three cases, which represented 2% of total number of patients with anterior uveitis that we studied. These results were similar to those published by Bañares *et al*, who found that the cause of anterior uveitis was SLE in 1.8% of their total cases.[7] We think that SLE as a cause of uveitis is more common than it has been classically described, and that determination of antinuclear and anti-DNA antibodies should be performed in patients with uveitis with some suggestive clinical signs of lupus.

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Accepted 25 October 2001

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Table 1 Clinical characteristics in three women with SLE and uveitis

Case No	Age (years) at uveitis flare	Age (years) at SLE diagnosis	Uveitis pattern	ACR criteria at uveitis presentation
1	55	55	AAU, NR	Malar rash, photosensitivity, pericarditis, ANA+
2	62	65	AAU, R	Malar rash, photosensitivity, leucopenia, lymphopenia, ANA, and anti-dsDNA+
3	52	52	AAU, NR	Malar rash, photosensitivity, leucopenia, lymphopenia, ANA, and anti-dsDNA+

AAU, Acute anterior uveitis; NR, non-recurrent; R, recurrent; ANA, antinuclear antibodies; anti-dsDNA, anti-double-stranded DNA antibodies.